‘Keeping a lid on it’: Exploring ‘problematisations’ of prescribed medication in prisons in the UK

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Abstract

Background: The non-medical use of prescription medication and risk of diversion have become policy and practice concerns within prison settings in the UK. These issues have been highlighted by the Advisory Council on the Misuse of Drugs, Her Majesty’s Inspectorate of Prisons and Her Majesty’s Prison and Probation Service (2019) prison drugs strategy. In 2019, new prescribing guidance was issued by the Royal College of General Practitioners for clinicians working within prison settings.

Methods: Informed by Bacchi's (2009) *What's the problem represented to be?* framework, the ways in which the ‘problem’ of prescribed medication in prisons have been represented is interrogated through an analysis of the prescribing guidance framework for clinicians working in prisons.

Results: Restrictive prescribing practices are recommended as a solution to the ‘problem’ of diversion and misuse of prescribed medication. Prescribers are advised to consider de-prescribing, non-pharmacological treatments and alternative prescriptions with less diversionary potential. They are represented as responsible for the ‘problems’ that prescribed medication bring to prisons. The guidance is underpinned by the assumption that prescribers lack experience, knowledge and skills in prison settings. People serving prison sentences are assumed to be ‘untrustworthy’ and their symptoms treated with suspicion. This representation of the ‘problem’ has a number of effects including the possibility of increasing drug-related harm, damaging the patient-doctor relationship and disengagement from healthcare services.

Conclusion: The representation of prescribed medication as problems of diversion and prescribing practices inhibits alternative representations of the problem which would inform different policy directions including improvements to regime and healthcare provision and would include a range of practitioners in prison settings to address the ‘problem’ more holistically.

Key words: problem representations, prescribed medication, diversion, prisons, Bacchi, United Kingdom

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Introduction

The non-medical use of prescription medication has become a policy concern across the globe. The United Nations Office on Drugs and Crime (UNODC) (2011, p. 1) defines non-medical prescription drug use as ‘the taking of prescription drugs, whether obtained by prescription or otherwise, other than in the manner or for the reasons or time period prescribed, or by a person for whom the drug was not prescribed’. In particular, the non-medical use of synthetic opioids has caused public health crises of increasing numbers of overdose deaths in some regions of Africa and North America (UNODC, 2021) and some European countries (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2021a). More recently, the non-medical use of sedatives (e.g. benzodiazepines and novel benzodiazepines) has been increasing and accelerated in many countries during the COVID-19 pandemic (Advisory Council on the Misuse of Drug (ACMD), 2020); UNODC, 2021; EMCDDA, 2021c). In the UK, there has been increasing concern about dependence, withdrawal and diversion associated with some types of prescription medication, specifically relating to benzodiazepines, z-drugs, gabapentinoids, opioids and anti-depressants (ACMD, 2016a; Public Health England (PHE), 2020). In their report on diversion and illicit supply of medicines, the ACMD[1] (2016a) dedicated particular attention to the problem of diversion and misuse of prescribed medication in prison settings. The escalation of diversion and misuse of prescribed medication in prisons has also been noted by Her Majesty’s Inspectorate of Prisons (HMIP) annual reports since 2011. The recent prison drugs strategy places emphasis on reducing the misuse of prescription medication and minimising the risk of diversion of these medicines (Her Majesty’s Prison and Probation Service (HMPPS), 2019). Although limited research has been undertaken, the concern about the diversion and misuse of prescribed medication in prison settings has also been highlighted across Europe (EMCDDA, 2021d) and in other countries, including the USA (Hatch, 2019), Canada (Brown, 2017), and Australia (Hampton et al., 2015).

[1] In the UK, the Advisory Council on the Misuse of Drugs (ACMD) was established in 1971 as an independent, advisory body that advises the government on the classification of drugs under the Misuse of Drugs Act 1971 and other drug-related issues.

In the UK, little is known about the use and misuse of prescribed medication in prisons. Only limited data exist about the nature and levels of prescribing in prisons. One study of English prisons identified that 47.9% of women and 16.9% of men were prescribed at least one psychotropic medicine, a considerably higher prevalence than in the community (Hassan et al., 2016). Other research suggests the prescription of some drugs, like pregabalin and gabapentin, is twice as high in secure settings in comparison to the community (Stannard, 2014); with concerns that prescription rates are increasing (ACMD, 2016a). In 2015, the HMIP conducted a review focused on the changing nature of substance use in prisons in England and Wales. The report highlighted the increased use of new psychoactive substances (NPS) as well as prescribed medicines. Almost one-fifth (18%) of respondents said they had misused at least one medication, most commonly painkillers (10%) and sleep medication (10%). In 2019/20, HMIP surveys found that 9% of men and 14% of women said they had developed a problem using medication not prescribed to them (HMIP, 2020). While respondents in Lloyd et al.'s (2017, p. 6) research report that diverted prescription medication is 'readily available' in prisons, data about diversion is limited, 'largely anecdotal and difficult to quantify' (ACMD, 2016a, p. 6). However, recent research by May et al. (2019; 2020) about motivations for use and diversion in community and prison settings in Wales, has provided important insights.

Inspired by the work of Hatch (2019) on psychotropics in carceral settings in the USA, we are interested in how the documentary record has represented prescribed medication in UK prisons. Drawing on Bacchi's (2009) *What is the problem represented to be?* framework, the aim of this paper is to critically explore how prescription medication in prison settings has been problematised and to lay the foundation for further research. We focus on the revised prescribing guidelines for clinicians in secure settings which were published in 2019 by the Royal College of General Practitioners (RCGP). It is important to focus on how prescribed drugs are problematised in this guidance because representations in such authoritative documents are likely to shape and impact upon the prescribing of medicine in prison settings and the healthcare of people who are detained.

Conceptual framework and methodology

The target audience for the RCGP (2019) *Safer Prescribing in Prisons* guidance (104 pages) is clinicians (e.g. prison doctors, psychiatrists, and nurses) working in prisons and other secure settings, as well as community clinicians who have patients moving in and out of these environments. The RCGP is the professional membership body for general practitioners in the UK, including England, Wales, Scotland and Northern Ireland. Their remit is 'to encourage, foster and maintain the highest possible standards in general medical practice' (RCGP, 2021, para 1). The guidance updates the first edition, published in 2011 and includes electronic links to resources, as well as expanded chapters on substance misuse and palliative care and one dealing with wider prescribing issues. There is clear emphasis that the document should be used as 'reference' alongside the 'fundamental principles of good medical practice' (RCGP, 2019, p. 5).

The document covers the most common medications misused in prisons and considers their suitability for use in secure settings (RCGP, 2019, p. 14). The focus is on the 'most problematic drug groups and preparations within those groups' (RCGP, 2019, p. 16) which includes psychotropics, opioid substitution treatment (OST), and pain medication. A traffic light system is used to evaluate medicines. Red medications are considered inappropriate for prisons due to their harm and misuse potential, amber medicines prescribed with caution when other choices are inappropriate or have been used without success, and green medicines considered as the first-line treatments as they carry lower risk (RCGP, 2019). After setting out the rationale for, and principles behind the guidance, specific chapters relating to insomnia, depression, substance use and misuse, anxiety, epilepsy, psychoses, neurodevelopmental disorders, pain (acute, persistent and neuropathic) and palliative care, are provided. The longest chapter relates to substance use and misuse, reflecting the document's particular problematisations of those with possible substance use histories.

Our analysis of the prescribing guidance is informed by Carol Bacchi's (2009) post-structuralist, *What is the problem represented to be (WPR)*? framework. This approach offers useful tools for critically analysing policy and its implicit assumptions. It has become a popular mode of analysis among critical drug and alcohol scholars across the globe and has been employed to analyse policy documents (e.g. Fraser and Moore, 2011; Bacchi, 2015; 2018; Pienaar and Savic, 2016; Calnan et al., 2018; Berends, 2020; Bjerge et al., 2020; Brown and Wincup, 2020; Fomiatti, 2020; Madden et al., 2021; Sebeelo, 2021), law/legislation (e.g. Barratt et al., 2017; Lancaster, Seear and Treloar, 2015b), case law (e.g. Seear and Fraser,

2014), policy position statements (e.g. Lancester, Duke and Ritter, 2015a), news media (e.g. Atkinson et al., 2019) and radio documentaries (e.g. Boyd, 2014). Within the prison setting, the WPR approach has been used to interrogate the ways in which NPS were problematised in English prison drugs policy (Duke, 2020) and the effects of Australian prison drugs policy on young men with histories of injecting drug use (Walker et al., 2018; 2020). To our knowledge, this is the first time that the WPR approach has been used to analyse clinical guidance for prison settings.

Bacchi and Goodwin (2016, p. 18) use the term 'policy' in the broadest sense to 'include both the activities of state institutions and of other agencies and professions involved in maintaining social order'. Bacchi's framework directs attention to the forms of 'problems' created within policies, official documents and other written 'texts'. Materials adopted for WPR analysis must be 'prescriptive' and understood 'as a form of proposal and a guide to conduct' (Bacchi and Goodwin, 2016, p. 18). In this sense, the prescribing guidance offers advice to prescribers as to how to conduct their work within prison settings. Different, adapted and alternative prescribing practices are proposed as a 'solution' to the issues raised by prescribing medication in prisons. Within the WPR approach, such proposals or guides to conduct are viewed as productive, creative and constitutive. 'Problems' are not fixed and waiting to be solved by policy proposals, rather the proposed solutions shape the 'problems' they are meant to address. WPR analysts do not examine 'problems' and 'solutions' separately, but begin with the proposal or postulated solution and work backwards to identify the implicit representation of the 'problem' within it (Bacchi, 2016). The framework consists of six interconnected questions:

1. What's the '*problem*' represented to be in a specific policy or policies?
2. What deep-seated *presuppositions and assumptions* underlie this representation of the 'problem'?
3. *How* has this representation of the 'problem' come about?
4. What is left *unproblematic* in this problem representation? Where are the silences? Can the 'problem' be conceptualised differently?
5. What *effects* are produced by this representation of the 'problem'?
6. How/where is this representation of the 'problem' *produced, disseminated and defended*? How could it be questioned, disrupted and replaced?

Step 7: Apply this list of questions to your own problem representations.

(Bacchi, 2009; Bacchi and Goodwin, 2016, p. 20)

The next section of the paper explores the first question in Bacchi's framework (i.e. What's the '*problem*' represented to be in a specific policy or policies?) and identifies the dominant problem representations within the prescribing guidance. These problem representations provide the point of departure for the remaining analysis which examines questions 2, 4 and 5. Bacchi (2009) advises scholars they do not need to address all questions in their analysis.

Representing the 'problem' of prescribed medication in prisons

The 'problem' of diversion

The primary focus of the RCGP (2019) guidance is misuse of prescription medication within prisons, and particularly with their diversion. This dominant problem representation is evident from the very start of the document. In the first few sentences, reference is made to the first edition for being 'one of the first publications to identify how *widely and easily prescribed medicines could be misused* [emphasis added]' (RCGP, 2019, p. 4). Now viewed as a 'universally accepted' problem, the guidance makes a further 112 references to 'misuse', 64 to 'abuse' and 64 to 'diversion' (or divert/diverted). Although the document provides no clear data in relation to prevalence or the scale of the 'problem', prescribers are nevertheless encouraged to think of it as a significant one. The guidance advises that: 'a *significant number* of prisoners will misuse prescribed medication' (p10); that 'psychotropic medications … are *often* traded in prisons' (p10); and that, '*many* prisoners will divert their prescribed treatment by trading it or selling it into the illicit prison economy' (p11) [emphasis added].

Notwithstanding the harms/risks that may follow from the open availability of prescription medication in prisons, one notable feature of the problem representation is the tendency to conflate the use of prescription medication with the wider illegal drug 'problem' in prisons. Throughout the guidance, there are many occasions where prescription medication use is discussed alongside illegal drug use as if they are the same, undertaken by similar people, with similar motivations and effects. For example, in relation to the prevalence of 'drug' use, the

guidance states that: ‘prescribed medicines and substances are widely used and misused in prisons’ (RCGP, 2019, p. 10). Moreover, ‘bullying, violence and intimidation are widely recognised in prisons and prescription medication and illicit substances play a major part’ (RCGP, 2019, p. 11). Hence, clear causal links are drawn between prescription medication (alongside illicit substances) with many security issues in prisons. This conflation of security issues, drug use and ‘users’, has important implications for how prescription medication is problematised. By linking it to the wider issue of illicit drugs in prison, its character becomes more ‘dangerous’ and ‘risky’ and the obligations on prescribers to behave differently are stronger.

The ACMD (2016a) draw attention to how prescription drug ‘misuse’ can take many forms, including: excess consumption; changes in administration method (i.e. crushing tablets and then snorting them); deliberate attempts to achieve a ‘high’; and diversion to others. While the prescribing guidance does refer to different types of misuse and the risks that may follow, there is a more explicit concern for diversion. Although practitioners are reminded of the possible risks that may follow from stockpiling medication, overdose, and possible litigation; the risk of medication being diverted and the problems this may generate for the wider prison environment are given more attention. For example:

> *‘The diversion of prescribed medication to the illicit prison economy also presents risk to the wider prison environment as individuals, groups and gangs within prisons continue in maladaptive and criminal behaviours that may put the safety of other individuals at risk’* (RCGP, 2019, p. 11).

The document’s emphasis on diversion over other types of misuse, prioritises the *safety of the wider prison environment* over *individual patient harms.* The guidance reminds prescribers that the ‘core function of imprisonment is … security and public protection’ (RCGP, 2019, p. 9) and that prescribed medicines present ‘enormous challenges to the safe running of prisons’ (RCGP, 2019, p. 10). Concerns with the safety of the wider prison environment appear to trump concerns for the individual healthcare needs of patients in prison, which may undermine principles of providing equivalent healthcare to them.

Our argument that the problem of ‘diversion’ rather than the problem of individual ‘(mis)use’ is prioritised in the document, can be further illustrated by considering the specific guidance

relating to buprenorphine (a key medication used for treating opioid dependence). Individuals may arrive in prison with existing prescriptions of buprenorphine issued in the community, and while the RCGP (2019, p. 45) acknowledges 'buprenorphine is *safer in overdose* [emphasis added] than methadone', the guidance nevertheless advises:

> *'methadone is the drug of choice for OST in prison, due to the greater risk of diversion and misuse of buprenorphine and the impact on the regime caused by the length of time taken for safe supervised consumption of buprenorphine'* (RCGP, 2019, p, 44).

This example illustrates the way in which the guidance serves to re-negotiate clinical understandings and behaviour in relation to the provision of 'equivalent' healthcare to those in prison. The principle of equivalence or the view that 'prisoners should have access to the same range and quality of services appropriate to their needs as are available to the general population' (Department of Health and HM Prison Service, 2001, p. 5) is emphasised in UK prisons (see Till et al., 2014 for a history) and in other countries (WHO, 2003). However, it is also a principle that is in many respects, aspirational (Ismail and De Viggiani, 2018) with many prison staff expressing doubts that it can be achieved (Caulfield and Twort, 2012).

The guidance notably provides a chapter at the outset about the 'equivalence of care in secure environments'. It provides a working definition of equivalence and sets out the RCGP's commitment to delivering healthcare of the 'highest possible standards' and of 'striving for 'equivalent' care' (RCGP, 2019, p. 7). Under a section entitled 'A different approach', it is explained: 'that 'equivalence' does not mean that care provision in secure environments should be 'the same' as that provided in the community' (RCGP, 2019, p. 7). One area of prison healthcare where there are clear exceptions to the principle of equivalence, is prescription medication. Within the prison environment, prescribing is represented not just as a matter for the individual patient and their prescriber, but for the whole prison population. Indeed, the guidance advises prescribers that:

> *'they have a responsibility, through prescribing appropriately for the environment in which they work, to reduce risks to the wider prison population'* (RCGP, 2019, p. 13).

This quote clearly illustrates attempts to responsibilise healthcare staff to act with a clear concern for issues of security, even if this may mean compromising principles of equivalence.

The priority of security over equivalence can also be observed in other strategies suggested by the guidance. One of these is the rather naïve emphasis on non-pharmacological treatments and self-care in prisons, which in some cases, may be contrary to the principle of equivalence:

> *'The opportunity to promote self-care and non-pharmacological treatments should be optimised in prisons. The choice of interventions should be patient-centred and include, for example, physiotherapy, psychological therapy and exercise. The promotion of activities to improve health and wellbeing should be encouraged. Imprisonment should be used to encourage prisoners to change their lifestyles. The use of non-drug therapies challenges over-reliance on pharmacological treatment and promotes self-care and self-reliance. Skills in deprescribing should be optimised by clinicians'* (RCGP, 2019, p. 10).

These general health and well-being interventions and provisions are important for all populations. However, Davies et al. (2020) point to the constraints around and lack of opportunities for self-care to manage health conditions in prisons. The reality is that the availability of non-pharmacological treatments in prisons (e.g. therapy, opportunities to exercise, arts-based activities etc.) are even more limited than they are in the community. Such treatments and activities in prisons have been severely impacted as a result of cuts, a lack of resources, and the lack of staff required to facilitate and supervise these interventions (HMIP, 2020; Howard League for Penal Reform and Centre for Mental Health, 2017). Thus, there is a clear disjuncture between the guidance and the available practices. For example, guidance on safer prescribing for sleep medication suggests alternatives such as sleep hygiene, exercise, mindfulness, meditation, and cognitive behavioural therapy (CBT). These are all provisions which are difficult to provide in prison settings (Dewa et al., 2017), particularly as a result of cell sharing, reduced regimes, cuts to programmes and other resource limitations.

In addition to encouraging prescribers to optimize their skills in de-prescribing, the guidance also urges them to be cautious in relation to dosage, method of administration and in-possession medication. For example, the guidance states:

> *'The fundamental principles of good prescribing using the smallest quantity of the lowest dose are advised. Extreme caution should be exercised in allowing patients to*

keep medicines 'in-possession' where there is any doubt regarding safety or concordance' (RCGP, 2019, p. 12).

Clinicians are also advised that they can use medicines 'outside of accepted community guidance and practice' where their assessment of risk to the environment and patient have been made:

'It may be appropriate to prescribe a medication that is outside of accepted community guidance and practice. It is defensible and appropriate to do this in circumstances where equivalence of care is being sought, having carefully considered and documented this risk evaluation (RCGP, 2019, p. 15).

The 'problem' of prescribing practices

Of course, people who are imprisoned cannot divert medication if they have no prescribed medication to divert. Closely linked to the problematisation of diversion, therefore, is the 'problem' of prescribing practices. It could be argued that this representation of 'problematic' prescribing practices connects to a wider global discourse and concern around excessive and inappropriate prescribing by some practitioners, particularly in relation to the opioid epidemic in the USA (Kiang et al., 2020). The RGCP (2019, p.11) state the fundamental principle of the guidance is 'to support prescribers in understanding which medicines are commonly misused and empowering prescribers to exercise appropriate caution'. Here, we can clearly see the problem representation of diversion and a perceived need to 'empower' prescribers to adopt a more restrictive approach. While the guidance is primarily targeted at clinicians in prisons, it is also relevant to community prescribers who need to consider how their prescribing decisions could affect treatment in custody and that:

'Rationalisation of a patient's care before detention may help the transition into custody and the care provided by the prison healthcare team' (RCGP, 2019, p. 4).

The inherent suggestion in the last few extracts is that prescription practices are problematic. The perceived solution to this is to educate prescribers about the risks of prescription medication in prisons, encourage (or empower) them to prescribe less, and finally, to encourage

prescribers to take responsibility for the 'problems' that prescriptions may bring to the prison environment. Prescribers are reminded that 'the acquisition, misuse and onward trading of prescribed medication cannot be supported and should be discouraged' (RCGP, 2019, p. 10). Prescribers are therefore encouraged to question the prescriptions that people 'claim' to have on arrival to prison and to consider discontinuing or amending them. The guidance highlights prescribers must make important decisions whether to 'continue, delay or cease prescribing' the medications people are taking on arrival to custody (RCGP, 2019, p. 18). Prescribers are further reminded of the need to ensure that 'they are not working in a *culture of profligate and inappropriate excessive prescribing* [emphasis added], a situation which is commonly encountered in many prisons' (RCGP, 2019, p. 14). These extracts illustrate that prescribing practices, in both the community and prisons, are represented as possibly being excessive or inappropriate. Built into the problem representation of prescribing practices are several assumptions about the skills and experience of those with responsibility for prescriptions as well as the trustworthiness of imprisoned people and the symptoms they report. We explore these in the section that follows.

Assumptions underlying the representation of the 'problem' of prescribed medication in prisons

The second question in Bacchi's (2009) framework asks us to consider: 'What deep-seated *presuppositions and assumptions* underlie this representation of the 'problem'? Underlying the dominant problem representation of prescribed medication in prison as a problem of 'diversion' and 'prescribing practices', are several presuppositions and assumptions. We begin with the assumption that prescribers may be 'irresponsible' or 'unskilled' in prison settings.

Prison prescribers as 'irresponsible' and 'unskilled'

Concerns about the 'problem' of prescribing practices rely on an inherent assumption that previous prescriptions issued in the community (or at other prisons) may be incorrect, inappropriate, and/or unsafe. Underlying this is an assumption that prescribers may be lacking in experience, training and skills, particularly in relation to the prison environment. To help 'support' prescribers and address their possible 'deficits', there is the assumption that clearer

guidance and training is required. Hence the guidance itself. Prescribing in prisons is described as a 'specialist area of practice' requiring:

> *'greater skill and vigilance such that the prescriber understands risks posed by the prison environment, the specific medicine and the effect of prescribing on an individual prisoner'* (RCGP, 2019, p. 10).

Elsewhere, prescribers are reminded that they 'have a duty to understand and acknowledge the potential impact of their actions and work with their security colleagues to find appropriate solutions' (RCGP, 2019, p. 7). Prescribers are constantly warned of the need to be cautious and 'judicious' in their prescription decision-making. Prescribers are responsibilised for educating themselves about the possible risks of their decisions and amending their prescription decisions accordingly. They are also responsibilised for reducing the *supply* of drugs in prisons. Bacchi (2009) encourages us to think about who is targeted as needing to change through a problem representation. Through the RCGP guidance, we can see that it is the prescribers who are expected to change their behaviour, rather than imprisoned people, or other actors in the prison environment, such as security staff.

'Responsible' prescribers are encouraged to expect diversion and misuse to be a reason behind requests for prescription medication, and to therefore act with extra caution and vigilance. Therefore, prescribers are told:

> *'Challenging a patient's requests, demands, wants and needs regarding prescriptions is one of the most difficult aspects of clinical practice. It requires training, experience, communication skills, professional support, teamwork, positive feedback and personal reflection'* (RCGP, 2019, p. 14).

Here, it is interesting that patient 'requests', 'demands' and 'wants' are all listed (and prioritised) before their 'needs'. Moreover, it is made explicit that clinical staff need to be skilled at 'challenging' such requests, and implicit in the guidance, is the suggestion that one way to deal with this responsibly would be to refuse them. The problematisation of diversion therefore draws on several assumptions about the behaviour of those imprisoned. There is a clear emphasis on treating them and their reported symptoms with suspicion.

Imprisoned people as 'untrustworthy'

Because diversion is presented as 'inevitable', there is also an assumption that people in prison are untrustworthy, and the health symptoms they report, should be treated with suspicion. Those with substance use histories are presented as particularly untrustworthy, and clinicians are reminded that '*particular caution* [emphasis added] should be exercised when prisoners with a history of illicit or illegal drug use' (RCGP, 2019, p. 12). In the chapter about pain management, prescribers are advised that '*extreme caution* [emphasis added] is needed in patients with a history of, or current, substance misuse' (RCGP, 2019, p. 81). It is important to note however, that prescribers are encouraged to be suspicious of *all* imprisoned people, even those without histories of substance use. Indeed, the document claims that 'many prisoners will divert their prescribed treatment' (RCGP, 2019, p. 11) and that:

> *'it is widely recognised that some patients will request prescribed medication for the psychotropic effect of the drug rather than its therapeutic or licensed use. Many though not all of these patients will have a previous history of substance* use' (RCGP, 2019, p. 10).

Elsewhere the guidance cautions prescribers that patients may be 'presenting with exaggerated or fictitious disorders in an attempt to obtain a prescription which will be misused or diverted into the illicit prison economy' (RCGP, 2019, p. 12) and that they 'may have non-epileptic seizures in order to obtain benzodiazepine medication' (RCGP, 2019, p. 68). These examples highlight how imprisoned people are routinely characterised as likely to try and deceive prescribers. They are reported to feign symptoms, to desire medications for their psychotropic effects (rather than 'legitimate' reasons) and as likely to divert them to others in prison. There are also brief reminders to prescribers of the risk of them 'stockpiling' drugs linked to later overdoses and of the risks involved with litigation; further emphasising that those imprisoned are not to be trusted. The inevitability with which diversion is presented, and the responsibilisation of prescribers to prevent prescription medication being available for diversion, suggests that people in prison cannot help but to deceive. The lack of autonomy afforded to people imprisoned also suggests an underlying assumption that those reporting symptoms, or requesting prescriptions, have very little chance of changing their 'criminal/addictive' behaviours and/or being rehabilitated; a linked assumption to which we now turn.

Linked to the assumption and characterisation of people in prison as untrustworthy, is an assumption that they are unlikely to change (particularly in relation to problem substance use) and that the prison environment is unlikely to support positive change. This pessimism regarding the potential of imprisonment to rehabilitate has been a recurring theme and subject to much debate in criminological research (e.g. Martinson, 1974; Farabee, 2005; Cullen et al., 2009). We can see this at work, early in the guidance, when it notes:

> *'the value of prison in the rehabilitation of offenders is open to question and the conditions in prisons have been questioned throughout their existence'* (RCGP, 2019, p. 9).

The guidance ultimately suggests there is little faith or trust in the 'recovery' of those who use substances or the 'rehabilitation' of those held in prison; so, the proposed solution to the problem of diversion in prison becomes better education of prescribers to encourage more restrictive practices. As discussed above, the conflation of prescription medication with the wider drug problem in prison is also relevant here – since the problematisation of 'diversion' assumes that all people imprisoned are trying to obtain drugs for nefarious reasons.

Silences in the problematisation of prescribed medication in prisons

The ways in which prescription medication in prison is problematised leads to several curious silences about other aspects of prescription medication *use* and *needs* (rather than diversion or misuse). In this section, we consider Bacchi's (2009) fourth set of questions (i.e. What is left *unproblematic* in this problem representation? Where are the silences? Can the 'problem' be conceptualised differently?) to explore the silences and how the 'problem' of prescription medication in prisons can be thought about differently.

Patient needs, experiences and motivations

While the document does make reference to the 'needs' of people in prison, this is not its primary focus. Moreover when 'needs' are discussed they are commonly contrasted with, and

not prioritised over, ‘risks’ to the prison environment. For those with significant opioid dependence and/or those needing palliative care, the guidance does suggest that some flexibility may be required. However, it is notable that the document makes only 17 references to the word ‘need’ and more than 200+ to derivatives of misuse, abuse and/or diversion. Prescribers are encouraged to think about the *risks* posed by *prisoners* rather than the *needs* of individual *patients.*

In their review of prescription medication use and diversion, the ACMD (2016a, p. 22) call for ‘improved support and information for patients about why prescribers have concerns about potential misuse of medications’. However, there is limited emphasis in the RCGP guidance about the need, and the ways in which to have open and honest discussions with patients in prison about their specific needs and the most suitable prescriptions for them within the prison environment. While the guidance encourages prescribers to ‘challenge’ patient requests for medication, it offers little advice about how this should be done, and how to involve patients in these conversations. At one point the document notes:

> *‘in many conditions prescribing may not be the preferred intervention. It is important that wherever possible patients are included in the prescribing decisions being made about them’* (RCGP, 2019, p. 99).

While this does highlight the need to ‘include’ patients in decisions about their medication, it also makes clear that prescribing might not be the course of action to take. This leaves limited room for patient involvement. The guidance also fails to engage with the value of (and need for) awareness raising and/or education of imprisoned people, about prescription medication use. There is also no clear attempt to think through how concerns about misuse and corresponding prescription decisions may be experienced by those in prison. While concerns about diversion may be legitimate, and reflective of concerns about well-being, more needs to be done to explore (and acknowledge) how particular restrictions on prescribing practice may be experienced by those who are subject to them; especially those with no histories or intentions of misusing drugs.

There is also a notable silence regarding *why* those in custody may divert prescribed medication. The reasons for using diverted prescribed medication in prison are complex and can be shaped by structural constraints. May et al. (2019) found that using for recreational

purposes was rare and that most people were using prescribed medication for therapeutic purposes to relieve legitimate illness or injury or to mitigate withdrawal symptoms from opiates. Diverted medication may also help fill a gap due to lack of treatment capacity and access to healthcare provision. Hassan (2012) found that patients in prison were using psychotropic medications to reduce symptoms relating to mental illness, to cope, and to reduce insomnia. Similarly, respondents in Wakeling and Lynch's (2020) research indicated that where healthcare access, particularly in relation to medication, was difficult, they were more inclined to turn to self-medication. This often occurred when prescribed medications were withheld, or as sleeping aids (ibid).

Although some people may be involved in diversion for individual financial gain, many are thought to have more altruistic motivations. Respondents in May et al.'s (2019) research would supply medication to friends for healthcare reasons when legitimately prescribed medication was difficult to obtain in prisons. These transactions were based on mutual obligation reciprocity. Their research highlights how 'social networks play an important harm-reducing role in a context of limited access to various prescription medications' (May et al., 2019, p. 38). It also reveals a 'culture of sharing' among those imprisoned (Mjåland, 2014). Amid the recent overdose epidemic in Vancouver, Canada, Bardwell et al. (2021) found that diversion was seen as a way of helping someone out, with prescribed medication seen as a 'safer' and 'cleaner' option than the illicit drug supply, with less risk of overdose. Against a background of poverty and deprivation, diversion was a method of getting money to pay for basic necessities such as food. Within the prison environment, diversion will also be the outcome of many situated rationalities and structural constraints. These medications become valuable currencies which can be exchanged for everyday goods such as food, toiletries, and vapes (May et al., 2019). In the UK, the prison drug market is saturated with synthetic cannabis with little information about composition or purity (User Voice, 2016; Ralphs et al., 2017). Diversion of prescribed medication may be seen as a way of providing a safer drug supply in prisons.

Research suggests that prison regimes, which are often highly structured and inflexible, can impact on medication adherence (Mills et al., 2011). Yet, there is a curious lack of attention towards medication adherence in the guidance. The preoccupation with diversion, and to a lesser extent individual misuse, means that nothing is said about the need to monitor patient prescription plans and to ensure that they are compliant with *taking* (rather than *giving away*)

their medication. Again, concerns for the wider prison environment are prioritised over concerns for individual patients.

Resources and the regime

In evidence submitted to the ACMD (2016b, p. 57), HMIP raised concern that those imprisoned may use diverted medication to help relieve the boredom that follows from a lack of purposeful activities. They called for additional resources to be made available for purposeful activities and for other activities, including mandatory drug testing (MDT). They also suggested the law should be changed to permit MDT to test for a wider range of drugs (which is now possible under the Prisons (Substance Testing) Act 2021), and for the need to raise awareness among those in custody of the risks involved with misusing prescription medication. Yet, limited attention is given to any of these wider issues in the RCGP guidance. For example, there are only two occasions (p12, p83) where reference is made to MDT. However, concern is expressed about how prescription opioids may help those imprisoned to hide their illicit drug use (rather than about issues relating to the provision/efficacy of MDT). Reflecting the problematisation of people in prison as 'untrustworthy' and the need for staff to be 'responsible', prescribers are reminded of the need to: recognise that by prescribing opioids they could be *complicit* [emphasis added] in masking illicit opioid use' (RCGP, 2019, p. 12).

This illustrates how prescribers are continuously made to take responsibility for diversion and misuse throughout the document, rather than other prison staff (security, management etc). There is a sense that if they prescribe, it is 'inevitable' that diversion and misuse will follow. The 'problem' is therefore presented as one of risky prescribing practices, rather than of resources or the regime. A similar silence can be observed in the problematisation of NPS in prison which is produced primarily as a law, order and control problem, requiring greater regulation and penalties, rather than as a demand problem, requiring education, treatment and harm reduction or as a regime problem requiring improvements to purposeful activities such as opportunities for education, training and work (Duke, 2020).

Wider healthcare provision

Linked to the failure to consider *why* those in custody may be motivated to divert their medication, the RCGP guidance also fails to adequately acknowledge the challenges they may

face with access to healthcare in prisons. Echoing the research findings above, the ACMD (2016a) also expressed concerns that people in prison may use diverted medication to self-manage health issues that are not adequately addressed. This may relate to the findings that nearly a third (32%) of those in custody have unmet medication needs (Jakobowitz et al., 2017) and that 4 out of 10 hospital appointments for those in prison are either cancelled or missed (Davies et al., 2020). The number of deaths from natural causes has been rising in prisons, with the average age of someone dying in custody just 56, compared to 81 in the general population (Independent Advisory Panel on Deaths in Custody and Royal College of Nursing, 2020)[2]. In their submission to the ongoing Justice Committee's inquiry into mental health in prisons, Inquest (2021, p. 2) raised concerns about 'critical delays in providing necessary medication for mental ill health in a timely and consistent manner'. Other concerns about inadequate end-of-life care for an increasingly ageing prison population, have also been raised by Hospice (2020). The problems that arise from inadequate healthcare provision and restrictive prescription practices therefore represent other silences in the RGCP guidance.

Effects produced by these representations of the 'problem'

In this final section, we explore the fifth question of Bacchi's framework: 'What *effects* are produced by this representation of the 'problem'? The representation of prescription medication as a 'problem' of 'diversion' and 'prescribing practices' has several effects. While it is essential to ensure that prescriptions are managed safely in a prison environment, greater attention needs to be given to the potential harms/risks that may follow from a restrictive approach to prescribing. An over-emphasis on security/control in the management of drugs in prisons, may generate a number of paradoxes of control, and actually serve to increase the harms surrounding drug use.

Medicine adjustment and restrictive prescribing

[2] This also reflects the fact that the population in prison is relatively young with a lower proportion of people aged over 50 (Ministry of Justice, 2021).

One possible ‘effect’ of the problematisation of prescription drugs, is changes in prescription practice. As our analysis has highlighted, there is a clear emphasis throughout the guidance for prescribers to make adjustments (downwards) to prescription medication in line with the wider security concerns of the prison. Prescribers are encouraged to think about delaying, reducing or stopping a patient’s medication and to question if their ‘claims’ are even true. They are also encouraged to use alternative formulations of a medicine (i.e. liquid, injection) to reduce risks, enabled to use unlicensed medications as alternatives to licensed medications that are felt to be particularly risky and permitted to prioritise concerns for security over principles of equivalence. Research confirms that prescribers are doing just this. Indeed, May et al. (2020) report that prescribers are adjusting people’s prescriptions when they arrive in prison, by switching some medication to alternatives, introducing supervised consumption of the medication and discontinuing medications which are considered to have high abuse potential. Research has also identified that patients in prison feel their prescriptions are changed without ‘adequate consultation and explanation, causing significant frustration and distress’ (Hassan, 2012, p. 204; see also Bowen et al., 2009; Hassan et al., 2013; Sullivan et al., 2016). To help address avoidable natural deaths in prison and to ensure continuity of care, the Independent Advisory Panel on Deaths in Custody and the College of Nursing (2020) have recently recommended that people should have immediate access to their community-prescribed medication on arrival to prison.

Distrust (and disengagement)

Concerns about the diversion of prescription medication can generate ‘atmosphere of distrust’ and disrupt the relationship between patients and doctors (ACMD, 2016a). The construction of people imprisoned as ‘untrustworthy’ and unlikely to be ‘rehabilitated’ is likely to have important effects on their subjectivities, how they respond to healthcare services and policies, and the expectations they may have of these services (Lancaster et al., 2014). Moreover, this construction inevitably limits the ways in which healthcare and drug services in prison can be thought about. Paradoxically, attempts to restrict the circulation of prescription medications may serve to discourage engagement with health and substance use services in prison. Restrictive practices also help remove responsibility from those in custody (for managing their own health and medication), which in turn, may undermine strategies of self-care.

Self-medication with diverted medication or illicit drugs

Research suggests that medicine adjustments, and the removal or reduction of pain medication, may force people into self-medicating (Higgins et al., 2019; May et al, 2019, 2020). More stringent controls, surveillance, monitoring and supervision may lead to unintended consequences such as pushing people into more harmful use in prisons (e.g. using the illicit prison drugs market to lessen the effects of opiate withdrawal, potentiating the effects of low-grade heroin, using NPS to deal with pain and other problems etc). Restrictive prescribing practices may therefore lead imprisoned people to source drugs through the illicit drug economy (Keene, 1997).

In the UK, some prisons have tried to prevent buprenorphine diversion by refusing to prescribe it; a situation which 'unacceptably inhibits recovery for some prisoners' (HMIP submission to ACMD, 2016a, p. 53). While concerns about diverted buprenorphine are valid, its unavailability or restricted use in prisons has contributed to poorer outcomes, particularly for those serving short sentences or on remand (HMIP, 2015). There is also evidence of buprenorphine misuse in prisons where it is not prescribed, revealing how inflexible prescription practices may lead to different supply routes (Tompkins et al., 2009) and the increased use of illicitly obtained drugs (HMIP, 2015, p. 59).

Increased risk to health

The priority of security concerns over individual healthcare needs in prisons, and a corresponding restrictive approach to prescription medication, may therefore serve to generate other harms. 'Coercive abstinence' policies to deal with opioid addiction in prisons, have paradoxically been linked to relapse, overdose and sometimes death (Stöver and Michels, 2010, p. 5). Research suggests that prison-based OST can significantly reduce opioid-related deaths following release (Bird et al., 2015; Marsden et al., 2017) and that people released from prison with ongoing prescriptions have lower rates of reoffending (Chang et al., 2017; Farrell-MacDonald et al., 2014). Yet, the latest HMIP (2020, p. 45) annual report states that some prisons continue to restrict the availability of some drug treatments due to security concerns, despite these practices contravening national prescribing policy and security practices.

The Prison and Probation Ombudsman (PPO) (2019) have recently expressed concern about a 'significant minority' of deaths in custody involving prescription medication. In addition to the 'presence' of prescription medication in some custodial deaths in custody, there is evidence to suggest that their 'absence' may also play a part in some fatalities. Indeed, a review by Inquest (2020, p. 8) of deaths in custody raises concern about the provision of poor healthcare and of a 'failure to review prescriptions and delays in accessing medication (both for physical and mental health needs)'. There is also evidence that people in prison may struggle to have their health concerns, or medical emergencies, acted on in a timely way (House of Commons Health and Social Care Committee, 2018). In their submission to the Justice Committee concerning Mental Health in Prison, Inquest (2021, p. 2) raise further concerns about 'a systemic culture of neglect and disbelief in responding to prisoners' request for mental health support', particularly for ethnic minority groups. These assessments illustrate how poor healthcare provision and the mistrust of people detained in prison, may serve to put some people with genuine health needs (rather than assumed substance use issues or desires to trade in the illicit prison drug market), at significant risk.

Increased subversion

Another possible effect produced from this problem representation is that diversion may begin to carry subversive meanings, creating solidarity and feelings of collective resistance for those living in such highly controlled settings. For example, Mjåland (2015, p. 781) found that the introduction of a dedicated opiate treatment unit to a Norwegian prison, was felt to be unfair and illegitimate by those in custody and experienced as 'excessive and repressive'. Paradoxically, the greater surveillance and control within the unit led to an increase of buprenorphine diversion because of 'a *defiant desire* [original emphasis] to subvert institutional rules and expectations' (Mjåland, 2015, p. 786). This reminds us how diversion, dealing and the use of drugs (both illicit and prescribed) in prisons may help to form important social and personal identities. Crewe's (2005; 2006) research on drug dealing in British prisons revealed involvement was bound up with self-identity, internal hierarchies, masculinity and status. It also helped those participants feel connected to a wider social group. Therefore, people who are imprisoned should not be framed as 'passive' recipients of these problem

representations, but 'active' with some ability to shape and counteract them, which may generate feelings of empowerment (Duke and Kolind, 2020).

Conclusion

The WPR analytical strategy highlights the productive role of prescribing guidance frameworks in shaping and producing particular understandings of the 'problem' of prescribed medication in prison. Diversion is represented to be the 'problem', so special regulations for prescribing in prisons are viewed as necessary in order to control the types of medication prescribed, the dosage and length of time they are prescribed and how they are administered (in the interest of safety for the prison population). The 'problems' are the practices (i.e. prescription and diversion). The assumptions underpinning these 'problems' are based on how key actors are represented (i.e. imprisoned people and prescribers). People who are imprisoned are viewed as untrustworthy, while prescribers are viewed as irresponsible and with skill deficits for their work within prison settings. Responsibility is therefore taken away from those imprisoned (because they cannot be trusted/will not change) and firmly placed on prescribers (who are reminded to be cautious and avoid being complicit). Prescribers are therefore tasked with containing or keeping a lid on the 'problem' of the supply of prescribed medication within the prison drugs market.

These problem representations are important for the processes and practices of governing people in prison who are prescribed medication. They have impact on resources and effects on those living and working in prison settings. The problem of equivalence of care is grappled with throughout the guidance. Neither equivalent prescriptions nor non-pharmacological care may be available to those imprisoned because of concerns about 'risk'. Given their high prevalence of physical/mental health needs, this raises significant issues in relation to their rights and care in prison. Restrictive prescribing practices may increase harms and risks to people in custody as they attempt to self-medicate with other more harmful illicit substances or diverted medication in the prison drugs market. The pre-occupation with diversion can create distrust, damage patient-doctor relationships and result in disengagement from healthcare services. While the RCGP guidance promotes the importance of self-care rather than the use of prescription medications, this is problematic when those imprisoned (and their needs and wishes) are largely overlooked. Individuals are given little autonomy when it comes to the type,

dosage, method and possession of their own medication because of wider concerns about diversion and risks to the prison environment. Yet, research suggests that giving patients in prison responsibility over key medication decisions can serve to encourage greater independence and responsibility, 'ultimately leading to improved health' (Hassan, 2012, p. 244).

The overwhelming focus on diversion and restricting prescribing practices inhibits other representations of the 'problem' which would inform different solutions or policies to address the 'problem'. There is no engagement with the question as to why those in custody might divert and use prescribed medication and how these actions are shaped by structural and regulatory constraints. The increasing use of both illicit and prescribed drugs could be represented as a 'problem' around the regime and lack of purposeful activity (i.e. education, work and other rehabilitative activities), or the effective 'warehousing' of people in prison (Irwin, 2004). During the working day, it has been documented that a fifth (19%) of people in prison are routinely locked up (HMIP, 2020). This problematisation would point to inadequate provision around exercise, hobbies, training, education, and rehabilitative courses and would bring in a wider range of actors and prison staff to address the 'problem'. The diversion and use of prescribed medication could also be represented as a 'problem' of inadequate healthcare provision as people in prison try to self-manage their physical and mental health problems by using diverted medication.

We remain unsure how applicable the findings from this analysis are to the prescribing guidance and role of prescribers in prison settings in other countries. More research attention is needed to explore these issues in other contexts. This paper has revealed the paucity of research on the use, misuse and diversion of prescribed medication in prison settings in the UK and other countries. In the UK, there is no public record of the number and type of prescriptions and little scrutiny of prescribing levels. There is also no available data in relation to the size of the diversion 'problem'. In their review of diversion of prescription medication, the ACMD (2016a, p. 21) state that 'although the data are soft and incomplete there is little evidence of organised crime being involved with ... [diversion] … or of unethical prescribing by doctors or non-medical prescribers'. Yet, despite this, the guidance frames diversion as a significant issue whereby those imprisoned are characterised as being motivated to divert to illicit (and organised) drug markets in prisons and prescribers' practices (and their possible complicity in these illicit markets) are questioned and presented as problematic. There is a clear need for

greater monitoring of the number and types of prescriptions and for research which examines the perspectives of those imprisoned on their needs for prescribed medication and reasons for diversion in prisons. Further research also needs to examine how different groups (i.e. women, ethnic minorities, older and younger people, and people with disabilities and neurodiversity) may be affected by prescribing practices. Research also needs to explore the perspectives of prescribers on how these regulatory prescribing frameworks affect their practice and how they interpret the advice within prisons. Moreover, given the Covid-19 pandemic has affected the types of and ways in which substances are used (EMCDDA, 2021b) and has had a significant impact on the provision of mental health care in prisons, with many therapies having been suspended (HMIP, 2021), more research is needed to understand how substance use and prescribing practices (and the related experiences and behaviour of those imprisoned) may have changed during this time.

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